

**New Jersey Department of Banking and Insurance
Valuation Bureau
P.O. Box 325
Trenton, NJ 08625-0325**

**APPLICATION FOR DESIGNATION AS A
HEMOPHILIA HOME TREATMENT HEALTH CARE PROVIDER
INSTRUCTIONS AND CHECKLISTS**

INSTRUCTIONS: *New and renewal applications should be submitted in September each year; applications submitted at other times will not be considered. Applications must be complete. If a question or requirement does not apply to an applicant's particular circumstances, the applicant must so indicate that, rather than ignoring the question or requirement.*

PART A: Form

The following checklist is provided to help applicants complete their applications properly. However, completion of the checklist shall not result in an application being deemed complete or approved. Applicants shall refer to N.J.A.C. 8:38C-2 for details.

- ☐ The application is being submitted in duplicate.
- ☐ At least one copy of the application is being submitted in paper format.
- ☐ The paper copy is being submitted in one or more two-or three-ring binders.
- ☐ Binders are labeled to indicate the number of binders included in the submission.
- ☐ Disks, if any, are labeled to indicate the number of disks included in the submission.
- ☐ The application is being sent to:

Mailing Address (US Postal Service):

N.J. Department of Banking and Insurance
Valuation Bureau
Attention: Hemophilia Treatment
Designation Application
PO Box 325
Trenton, NJ 08625-0325

Overnight Services (UPS, FedEx, Airborne):

N.J. Department of Banking and Insurance
Valuation Bureau
Attention: Hemophilia Treatment
Designation Application
20 West State Street
11th Floor
Trenton, NJ 08625

- ☐ All copies of registrations, licenses and permits are enclosed.
- ☐ The application includes a certification signed by an officer of the applicant company.
- ☐ The officer's name and title is printed in the certification.
- ☐ The application contains a Table of Contents.
- ☐ The application is tabbed consistent with the Table of Contents.
- ☐ The pages of the application are numbered, and pages intentionally left blank are so indicated.

**INSTRUCTIONS AND CHECKLIST FOR APPLICATION FOR DESIGNATION AS A
HEMOPHILIA HOME TREATMENT HEALTH CARE PROVIDER
(Continued)**

PART B: Content

The following checklist is provided to help applicants complete their applications properly. However, completion of the checklist shall not result in an application being deemed complete or approved. Applicants shall refer to N.J.A.C. 8:38C-2 for details.

- ☐ Copies of all registrations, licenses and permits issued to the applicant by the State of New Jersey pursuant to Titles 45 and 26 of the New Jersey statutes or N.J.A.C. 13:45B-14 are enclosed.
- ☐ The application includes evidence of the applicant's ability to provide all blood products, including low, medium and high-assay levels.
- ☐ The application includes evidence of the applicant's ability to provide all needed ancillary supplies for the treatment of bleeding episodes, including blood infusion equipment and cold compression packs.
- ☐ The application includes evidence of the applicant's ability to deliver prescribed services and supplies within three hours after receipt of a prescription, 24 hours per day, year-round.
- ☐ The application includes evidence of the applicant's experience in management of bleeding disorders.
- ☐ The application includes evidence of the applicant's ability to perform appropriate recordkeeping and to maintain appropriate records.
- ☐ The application includes evidence of the applicant's ability to monitor and participate in product recall notification systems.
- ☐ The application includes evidence of the applicant's willingness to assist, and experience in assisting, individual clients in addressing third party reimbursement issues.
- ☐ The application includes evidence of the applicant's compliance with safe handling standards with respect to biological products, including removal and disposal of hazardous waste products.
- ☐ The application includes evidence of the applicant's policies and procedures regarding discontinuation of services and supplies when individual clients are no longer able to assure payment for services and supplies, and willingness to share these policies and procedures with individual clients and carriers.
- ☐ The application includes evidence of the applicant's ability and willingness to disseminate information to individual clients regarding the applicant's schedule(s) of costs, including projections of probable costs to individual clients based on an individual client's health benefits plan(s).
- ☐ The application includes evidence of the applicant's credentialing and recredentialing program for health care practitioners and other health care providers employed by or with which the applicant contracts for services and supplies.